

Intensive Care

HOW THREE STATES REDUCED THE COST

BY LARRY J. PFANNERSTILL AND DAVID F. OGDEN

In 1998 (ancient history by now) an estimated **\$117 billion**—almost **12%** of all personal health care expenditures in the United States—were spent on long-term care (LTC) services. Expenses for LTC services are projected to **more than double** between 2000 and 2025 and **nearly quadruple** by 2050. An increasing percentage of these costs is being covered by Medicaid (see chart). Medicaid covered **39%** of LTC costs in 1998, **43.8%** in 1999, and **45%** in 2000.

Most people think of long-term care services as institutional care delivered in a nursing facility. However, long-term care also includes services delivered in intermediate care facilities for the mentally retarded as well as home health care and related services, often referred to as home- and community-based services (HCBS).

Typically, people need LTC services when they have difficulty performing some activities of daily living (ADLs). These include bathing, dressing, eating, transferring, and toileting. Or they may have a cognitive impairment such as Alzheimer's disease.

The lack of ability to perform certain ADLs doesn't mean that long-term care services have to be provided in a nursing facility. From the point of view of a state's Medicaid budget, home care is preferred because it's usually less expensive than confinement in a nursing home. Equally, there are several advantages for patients to receive care in their homes, including an increased sense of independence and the ability to remain with and be cared for by family members.

Fortunately, Medicaid law allows the Centers for Medicare and Medicaid Services (CMS) to waive certain requirements so

that states can offer a broad range of home and community-based services to people who would otherwise need institutional care. Many states have waiver programs, which frequently incorporate managed-care components that coordinate acute-care and long-term care services through one system instead of the fragmented approaches that exist in Medicaid fee-for-service. The waiver programs also incorporate cost saving mechanisms through the transfer of risk to participating health plans that cover these community LTC services. Others typically coordinate acute care and LTC services through one system and also incorporate cost-saving mechanisms through the transfer of risk to participating health plans.

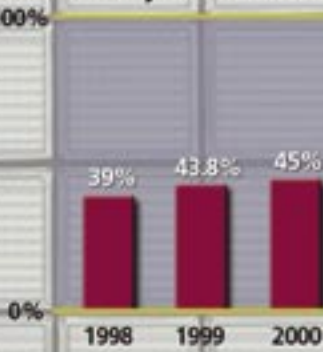
This article discusses three state programs that have successfully reduced Medicaid expenditures for LTC services through coordination of care and risk transfer. We discuss the program designs and covered populations for each program as well as the actuarial aspects of establishing rates and transferring risks through the structure of payments to the health plans.

The general actuarial expertise required to establish these programs is quite similar to that needed to project premium rates for a health insurance product. The actuary must analyze

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OF CARING FOR THE ELDERLY

Percentage of Long Term Care Costs Covered by Medicaid



Actuarial expertise was important to each of these

the appropriate historical data that applies to the covered population, make needed adjustments to reflect the services offered, and trend the experience data to the rating period to set the final premiums.

Each of the plans discussed, however, has unique features that must be considered before the typical recipe for rate setting can be followed. Actuarial expertise was important to each of these programs well before the final premium rates were set. The programs looked to the actuary to assist in analyzing the unique risk factors of the populations to be included and any potential for changes in utilization of services from historical patterns. The rate structures of the plans were then designed to encourage the management of services to reduce costs.

WISCONSIN

Family Care—7,746
enrolled in Oct. 2003;
9.7% savings 2001

WISCONSIN'S FAMILY CARE PROGRAM was started in 1998. Its goal was to provide flexible LTC benefits that were both comprehensive and cost-effective. The program serves physically or developmentally disabled adults and the frail elderly over age 65.

The system has two organizational components that work together to provide the appropriate services efficiently. The aged and disability resource centers are designed to be a single entry point to the system where people and their families can obtain advice and information on the wide range of resources available in their local communities. These centers operate in nine counties and focus on providing information, assistance, and counseling on available LTC services.

The resource centers also screen individuals to assess their level of need for LTC services and their eligibility for family care services. Once staff determines the level of need, they explore options of services that meet the individual's needs and preferences for the appropriate level of care. Those eligible for Medicaid may elect to stay in the fee-for-service program or enroll in Family Care. If they choose Family Care, the resource center will then enroll the person into the second component of the system, a Care Management Organization (CMO).

The CMOs have access to the full range of services offered by Medicaid, along with LTC services included in the Home and Community Based Waivers and additional community programs. Before Family Care, there was much concern that the state's LTC system was confusing and fragmented, with a bias toward institutional services. The CMOs develop and manage comprehensive networks of LTC service providers, including both home care and nursing facilities.

The CMO receives a single per member, per month capitation amount to provide all LTC services (acute-care services are excluded). CMOs use an interdisciplinary team that at a minimum, consists of a social worker and a registered nurse to address the unique needs of individuals and their family members.

The single payment for all services effectively eliminates any bias toward one care setting over another. The CMOs that serve the five Family Care counties all have accepted full risk for providing services covered by the capitation. The care management and support coordination is vital to the financial success of the CMOs in Wisconsin's Family Care program.

As of Dec. 31, 2002 there were 6,966 people enrolled with a CMO through the Family Care program. Of these, approximately 76 percent were frail elderly, 14 percent were developmentally disabled, and 10 percent were physically disabled adults. The program's enrollment had increased 11 percent to 7,746 by October 2003.

The Wisconsin Department of Health and Family Services estimated that the capitation amounts paid through Family Care in 2000 were \$153 per member per month (8.2 percent) less than the average monthly costs in the existing fee-for-service programs for LTC services. The estimated savings estimates in 2001 rose to almost \$200 per member per month (9.7 percent) in 2001.

Applying that savings estimate to recent enrollment implies that the program reduced costs in the fee-for-service program by about \$16.7 million in 2002. For comparison purposes, the total budget for Family Care in fiscal year 2003 is \$155.9 million.

MINNESOTA

MSHO—4,876 enrolled in
Jan. 2003; 5% decrease in
nursing facility days

THE MINNESOTA SENIOR HEALTH OPTIONS PROGRAM (MSHO) integrates acute and LTC services through Medicare and Medicaid financing. MSHO is a health care program for seniors aged 65 and over who, in the original design, were eligible for both Medicare and Medicaid. The program was recently revised so that people only covered by Medicaid are also eligible to enroll. MSHO is a voluntary program and seniors retain their choice to remain in the traditional Medicaid fee-for-service program.

There are currently three health plans serving MSHO enrollees in the seven-county Minneapolis/St. Paul metropolitan area, as well as three rural counties. These health plans offer all Medicare and Medicaid acute-care services as well as LTC services, including personal-care attendant services, home- and community-based services, and nursing facility care.

Out of the 4,875 MSHO enrollees as of January 2003, approximately 62 percent are institutionalized, while 16 percent meet nursing home requirements but receive home- and community-based services to remain in the community. The remaining 22 percent reside in the community and don't qualify for nursing home services.

The high concentration of nursing home residents in the program isn't unexpected. Since the program is voluntary, the participating health plans tend to attract enrollees to MSHO

programs well before the final premium rates were set.

from their existing Medicaid membership base. Overall, Minnesota has a higher proportion of institutionalized Medicaid members than other states, primarily due to the greater concentration of nursing facility beds in the area vs. home-health providers, which is typical of the upper Midwest region.

The rate structure encourages the participating health plans to enroll people in the community. There's evidence that the incentives are working; community enrollment in MSHO grew by 28 percent in 2002 while institutionalized enrollment decreased by 2 percent.

The voluntary nature of the program was a contributing factor to its rate structure, according to Pam Parker, MSHO program director. There are four general rate-cell categories based on where the enrollees receive services and the level of care required: community well, community nursing home certifiable, conversion from nursing facilities to the community, and institutionalized.

Each of the general rate categories is further separated into age ranges and a geographical grouping of counties. The health plans are paid a single capitation rate and are at risk for all Medicare and Medicaid services, including the first 180 days of a nursing facility stay. Nursing facility days beyond 180 are paid through Medicaid fee-for-service.

The rate structure provides a financial incentive for the health plans to reduce nursing home utilization. The portion of

the capitation rate for the nursing facility risk is paid only while the enrollee resides in the community. As a further incentive, the portion of the capitation rate for Medicare services uses the CMS demographic factor of 2.39 (the Federal PACE program multiplier, which is higher than the institutional demographic factor) if the enrollee transfers out of the nursing facility to the community. The change in the demographic factor results in an increase of approximately 50 percent to 60 percent in the portion of the capitation rate for Medicare services compared to non-institutional Medicaid enrollees.

The program has successfully reduced the utilization of nursing facilities. Over the six years ending in 2002, nursing facility days per MSHO enrollee were approximately 5 percent fewer than in the fee-for-service program. This reduction applies only to nursing facility stays of 180 days or fewer, but there's additional evidence to suggest a residual impact on the use of nursing facilities for stays beyond 180 days. This reduction is probably understated as health plans are probably using nursing facilities as a cost saving alternative to short rehabilitation stays in a hospital setting.

Savings are also explicitly built into the portion of the capitation rate for home and community based services. Projected fee-for-service costs are reduced by 5 percent when calculating the portion of the capitation rate for these services.

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ARIZONA ALTCS—37,645 enrolled in Aug. 2003; 20% reduction in members in nursing homes

THE ARIZONA LONG-TERM CARE SYSTEM (ALTCS), which started in 1989, serves the elderly and the disabled. Participants must pass both financial and medical screening.

Arizona's system is different in that it's a mandatory managed care program. All people covered by Medicaid who pass both the financial and medical screen are enrolled in ALTCS. Only tribal members who reside on reservations and receive care through the Indian Health System are exempt.

The medical screen is conducted by a registered nurse or social worker to determine if the individual is at immediate risk for institutional care. The screening is completed by state-employed staff and is subject to strict quality control standards and review. Until mid 2001, only one program contractor operated in each county in Arizona. Three contractors serve Maricopa County (metropolitan Phoenix area).

As in the other state programs, covered services including acute-care services, case management services, home- and community-based care services, and institutional services are integrated into a single delivery system. The program contrac-

tor assigns each member a case manager who coordinates care with the member's choice of primary care provider. There were 37,645 members in ALTCS as of August 2003. Of these, 59 percent were elderly or physically disabled and 41 percent were developmentally disabled. Approximately 59 percent of all members are concentrated in Maricopa County.

As in the other programs, the participating contractors accept a capitation rate and are fully at risk to provide all covered services. The ALTCS program rates are structured to provide incentive for contractors to increase the use of HCBS. Capitation rates are established assuming a target mix of HCBS and other services based on historical experience and projected trends in the use of HCBS services. At a retrospective settlement, the contractor receives a share of the savings if the actual mix of HCBS services exceeds the target. The plan is also at risk of financial losses, however, if the mix of HCBS services falls short of the target.

The Arizona program has succeeded in lowering total Medicaid health costs by providing a wide range of home- and community-based services in place of nursing facility care and restricting eligibility to those people who are most in need of services.

Studies show a savings of approximately 16 percent over long-term costs in comparable fee-for-service programs. The percentage of ALTCS members who reside in their own homes has increased steadily, from 35.9 percent in 1998 to 40.8 percent in 2002.

In addition, the percentage residing in adult foster care, assisted living, or behavior-health settings has increased from 5.2 percent to 12.5 percent over the same time period. This shift toward home- and community-based services resulted in a decrease in the percentage of ALTCS members residing in a nursing home, from 58.8 percent in 1998 to 46.6 percent in 2002 in the most recent five years of the program.

Each of these programs is unique in program design, integration of acute-care and LTC services, and financial incentives for the participating health plans to control costs. However, each program succeeded in reducing the cost of providing LTC services for the Medicaid eligible population.

As the cost for providing these services continues to increase, other states are likely to take proactive steps to implement programs that eliminate the barriers in fragmented systems of alternatives to traditional LTC services. The three programs in Arizona, Minnesota, and Wisconsin are prime examples of how the overall cost of providing Medicaid-funded LTC services can be reduced and help reduce the burden on state budgets while providing the potential to also improve the quality of life to the participants. The design and implementation of these programs is best accomplished with the assistance of sound actuarial analysis, to ensure a reasonable likelihood of favorable results. ●

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